APPENDIX C

Assistance with Completing this Application

You can choose an authorized representative.

You can give a trusted person permission to talk about this application with us, see your information, and act for you on matters related to this application, including getting information about your application and signing your application on your behalf. This person is called an "authorized representative". If you ever need to change your authorized representative, contact Medicaid. If you're a legally appointed representative for someone on this application, submit proof with the application.

1. Name of authorized representative (First name, Middle name, Last name)		
2. Address		3. Apartment or suite number
4. City	5. State	6. ZIP code
7. Phone number		
8. Organization name		9. ID number (if applicable)

By signing, you allow this person to sign your application, get official information about this application, and act for you on all future matters with this agency.

10. Your signature	11. Date (mm/dd/yyyy)

For certified Medicaid Application Centers only:

1. Application start date (mm/dd/yyyy)	
2. First name, Middle name, Last name, & Suffix	
3. Organization name	4. ID number (if applicable)

For Nursing Facility Trusted Users only:

By signing below, the Nursing Facility Trusted User agrees to abide by the conditions of this agreement and accepts responsibility for fulfilling all responsibilities encompassed within the scope of the authorized representation to the same extent as the individual the Long Term Care (LTC) facility represents. And agrees to maintain, or be legally bound to maintain the confidentiality of any information regarding the applicant or beneficiary provided by LDH. And will adhere to the regulations in 42 CFR Part 431, Subpart F and at 45 CFR 155.260(f)(relating to the confidentiality of information), 42 CFR 447.10 (relating to the prohibition against reassignment of provider claims as appropriate for a facility or an organization acting on the facility's behalf), as well as other relevant State and Federal laws concerning conflicts of interest and confidentiality of information.

1. Application Date (mm/dd/yyyy):	
2. Trusted User's First, MI, Last Name:	3. **Trusted User's Signature / Date:**
4. Name of nursing facility for which Trusted User is properly authorized:	5. Nursing Facility Location ID:

NEED HELP WITH YOUR APPLICATION? Visit www.medicaid.la.gov or call us at **1-888-342-6207**. If you need help in a language other than English, call **1-888-342-6207** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **1-800-220-5404**.